(b)(6)
(b)(3)

Standard Form No. 2810 U.S. Civil Service Commission FPM Supplement 890-1 November 1965	FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM **NOTICE OF CHANGE IN HEALTH BENEFITS ENROLLMENT**	2810-106

Part A.—IDENTIFYING DATA

1. NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	2. DATE OF BIRTH	3. CARRIER CONTROL NO.
Caranci	John	C.	2-7-22	078546

4. ADDRESS
64 Eddy Street
Centerdale, Rhode Island 02911

5. PAYROLL OFFICE NO.

6. ENROLLMENT CODE NO. 422

7. DATE THIS ACTION BECOMES EFFECTIVE
1 April 1970

ONLY THE ITEM WHICH IS CHECKED BELOW AFFECTS YOUR ENROLLMENT. READ THAT ITEM CAREFULLY AND FOLLOW ANY PERTINENT INSTRUCTIONS. KEEP THIS FORM UNLESS YOUR ENROLLMENT IS TERMINATED AND YOU APPLY FOR CONVERSION.

Part B.—TERMINATION

☐ YOUR ENROLLMENT TERMINATES ON THE DATE IN PART A, ITEM 7, ABOVE.

Part C.—CHANGE IN PLAN

☐ YOUR ENROLLMENT SHOWN IN PART A, ITEM 6, ABOVE HAS BEEN TERMINATED BECAUSE OF YOUR ENROLLMENT IN ANOTHER PLAN.

Part D.—TRANSFER OUT

☐ YOUR ENROLLMENT CONTINUES BUT IS TRANSFERRED TO YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM):

Part E.—TRANSFER IN

YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM) SHOWN IN PART K BELOW HAS ACCEPTED TRANSFER OF YOUR ENROLLMENT AND WILL CONTINUE IT. ☒

Part F.—SUSPENSION

☐ YOUR ENROLLMENT HAS BEEN SUSPENDED, EFFECTIVE ON THE DATE IN PART A, ITEM 7, ABOVE.

Part G.—REINSTATEMENT

YOUR ENROLLMENT HAS BEEN REINSTATED, EFFECTIVE ON THE DATE IN PART A, ITEM 7, ABOVE. ☐

Part H.—CHANGE IN NAME OF ENROLLEE

THE NAME IN WHICH THIS ENROLLMENT IS CARRIED HAS BEEN CHANGED TO: ☐

NAME | ADDRESS IF DIFFERENT FROM PART A, ITEM 4, ABOVE | DATE OF BIRTH

Part I.—CHANGE IN ENROLLMENT—SURVIVOR ANNUITANT

YOUR ENROLLMENT HAS BEEN CHANGED FROM FAMILY COVERAGE TO SELF ONLY. YOUR PLAN WILL SEND YOU A NEW IDENTIFICATION CARD. ☐

YOUR NEW ENROLLMENT CODE NUMBER

(NOTE: THIS ITEM TO BE COMPLETED BY RETIREMENT SYSTEMS ONLY)

Part J.—REMARKS

Employee Annuitant

Part K.—DATE OF NOTICE

SIGNATURE OF AUTHORIZED AGENCY OFFICIAL | DATE

Chief,

NAME OF AGENCY | ADDRESS

☆ U. S. GOVERNMENT PRINTING OFFICE: 1965 — 786-490

Quadruplicate —To Employing Office

INSTRUCTIONS FOR EMPLOYING OFFICES

PURPOSE OF FORM

This form covers health benefits actions except enrollments, changes of coverage within a plan, and cancellations which are processed on Health Benefits Registration Form (SF 2809). When an action requires a change in health benefits enrollment, prepare SF 2810 as soon as the effective date is known and give the appropriate copies to the enrollee and payroll office immediately. Preparation and distribution of copies should not be delayed pending SF 50 action in the case of transfers to another payroll office.

PROMPT ACTION REQUIRED FOR CONVERSION

To be eligible to convert to a nongroup contract, enrollee must furnish his copy of this notice to his Plan not later than 31 days after the date shown in Part A, item 7, or 15 days after the date shown in Part K, whichever gives him more time. Therefore, make this form available to the enrollee as soon as possible.

COMPLETION OF FORM

PART A—IDENTIFYING DATA

1. For items 1, 2, 3, and 6, transcribe from the last SF 2809 or SF 2810, whichever is the most recent.
2. Item 4, use most recent known address.
3. Item 5, use payroll office number of office authorized to process withholdings.
4. Item 7, date as follows for action reported in:
   - B. TERMINATION—Last day of pay period in which separation (or other action terminating enrollment) occurs except, when coverage terminates because of completion of 365 days in nonpay status, use date of 365th day.
   - C. CHANGE IN PLAN—Last day of pay period preceding effective date of election to change plans.
   - D. TRANSFER OUT—Actual date.
   - E. TRANSFER IN—Actual date.
   - F. SUSPENSION—Actual date.
   - G. REINSTATEMENT—Actual date.
   - H. CHANGE IN NAME OF ENROLLEE—Actual date.
   - I. CHANGE IN ENROLLMENT—SURVIVOR ANNUITANT—Effective date of sole survivor's annuity.

PART B—TERMINATION

These most frequently occurring actions terminate enrollment with enrollee eligible to convert to individual contract:

Separated
Furloughed by reason of reduction in force
Retired—not eligible to continue enrollment
Died—no survivor eligible to continue enrollment
Termination of title to annuity or compensation
Changed to excluded position or category
365 days nonpay status completed
Entered military duty not limited to 30 days or less
Employee organization gives notice to terminate employee's enrollment in organization's plan.

PART D—TRANSFER OUT

Losing office use this box to report transfer actions, such as:

Transferred to another agency or payroll office number (Do not use SF 2810 for transfer between employing offices serviced by the same payroll office number)
Retired—Transfer to a retirement system—employee appears eligible to continue enrollment as an annuitant
Death—Transfer to retirement system—survivor appears eligible to continue enrollment as a survivor annuitant
Transferred to Bureau of Employees' Compensation.

PART E—TRANSFER IN

Gaining office use this box to report transfer actions, such as:

Acceptance of transfer from another agency or payroll office number
Retired—Acceptance of transfer by retirement system because employee is eligible to continue enrollment as an annuitant
Death—Acceptance of transfer by retirement system because survivor is eligible to continue enrollment as a survivor annuitant
Transfer accepted by Bureau of Employees' Compensation.

NOTE: Retirement systems (including BEC) accepting transfer in, show also in "Remarks" whether enrollment is for an "EMPLOYEE ANNUITANT" or "SURVIVOR ANNUITANT."

PART F—SUSPENSION and PART G—REINSTATEMENT

State in "Remarks" reason for any action not applicable to active military duty such as "Reinstatement of erroneous separation."

PART H—CHANGE IN NAME OF ENROLLEE

Use this box only for reporting changes in name where change of coverage within a plan by SF 2809 is not involved. Show date of birth only where enrollment is changed from employee's or annuitant's name to name of survivor annuitant.

PART I—CHANGE IN ENROLLMENT—SURVIVOR ANNUITANT

Only agencies administering retirement systems will make this determination on the basis of documentary evidence that there is only one survivor annuitant.

PART J—REMARKS

Use this box to bring to the attention of the employee, annuitant, or carrier any pertinent information to clarify or support the action being taken.

PART K—DATE OF NOTICE

Facsimile signature is acceptable. Date as of day of issuance.

DISPOSITION

ORIGINAL—Deliver (or mail) to employee, annuitant, or survivor at earliest possible date. In case a termination SF 2810 must be issued more than 75 days after the effective date of termination, destroy the original copy.

DUPLICATE and TRIPLICATE—Send to appropriate payroll office.

QUADRUPLICATE—File in Official Personnel Folder (or its equivalent) except in cases of death or retirement reported as "Transfer Out" to a retirement system (including Bureau of Employees' Compensation). In latter cases, send the triplicate copy of each Health Benefits Registration Form (SF 2809) accepted from the employee including any Medical Certificates attached thereto and this quadruplicate SF 2810 to appropriate payroll office for transmission to agency or office administering retirement or compensation system.

U.S. Civil Service Commission

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

NOTICE OF CHANGE IN HEALTH BENEFITS ENROLLMENT

2810-110

Part A.— IDENTIFYING DATA

1. NAME (LAST)	(FIRST)	(MIDDLE INITIAL)	2. DATE OF BIRTH	3. CARRIER CONTROL NO.
Caranci,	John	C.	2-7-22	078546

4. ADDRESS (INCLUDING ZIP CODE)

64 Eddy Street
No. Providence, Rhode Island 02903

5. PAYROLL OFFICE NO.

6. ENROLLMENT CODE NO. 422

7. DATE THIS ACTION BECOMES EFFECTIVE
31 March 1970

ONLY THE ITEM WHICH IS CHECKED BELOW AFFECTS YOUR ENROLLMENT. READ THAT ITEM CAREFULLY AND FOLLOW ANY PERTINENT INSTRUCTIONS. KEEP THIS FORM UNLESS YOUR ENROLLMENT IS TERMINATED AND YOU APPLY FOR CONVERSION.

Part B.—TERMINATION

☐ YOUR ENROLLMENT TERMINATES ON THE DATE IN PART A, ITEM 7, ABOVE.

Part C.— CHANGE IN PLAN

☐ YOUR ENROLLMENT SHOWN IN PART A, ITEM 6, ABOVE HAS BEEN TERMINATED BECAUSE OF YOUR ENROLLMENT IN ANOTHER PLAN.

Part D.—TRANSFER OUT

☒ YOUR ENROLLMENT CONTINUES BUT IS TRANSFERRED TO YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM):

Retirement & Disability System
Washington, D. C.

Part E.—TRANSFER IN

YOUR NEW PAYROLL OFFICE (OR RETIREMENT SYSTEM) SHOWN IN PART K BELOW HAS ACCEPTED TRANSFER OF YOUR ENROLLMENT AND WILL CONTINUE IT. ☐

Part F.— SUSPENSION

☐ YOUR ENROLLMENT HAS BEEN SUSPENDED, EFFECTIVE ON THE DATE IN PART A, ITEM 7, ABOVE.

Part G.— REINSTATEMENT

YOUR ENROLLMENT HAS BEEN REINSTATED, EFFECTIVE ON THE DATE IN PART A, ITEM 7, ABOVE. ☐

Part H.— CHANGE IN NAME OF ENROLLEE

THE NAME IN WHICH THIS ENROLLMENT IS CARRIED HAS BEEN CHANGED TO: ☐

NAME	DATE OF BIRTH	SEX
		☐ MALE ☐ FEMALE

ADDRESS (INCLUDING ZIP CODE) IF DIFFERENT FROM PART A, ITEM 4, ABOVE

Part I.— CHANGE IN ENROLLMENT — SURVIVOR ANNUITANT

YOUR ENROLLMENT HAS BEEN CHANGED FROM FAMILY COVERAGE TO SELF ONLY. YOUR PLAN WILL SEND YOU A NEW IDENTIFICATION CARD. ☐

YOUR NEW ENROLLMENT CODE NUMBER

(NOTE: THIS ITEM TO BE COMPLETED BY RETIREMENT SYSTEMS ONLY)

Part J.— REMARKS

Part K.— DATE OF NOTICE

5-21-70
DATE

Central Intelligence Agency
NAME OF AGENCY

Washington, D. C. 20505
ADDRESS (INCLUDING ZIP CODE)

HEALTH BENEFITS OFFICER (ALTERNATE)

Quadruplicate —For Official Personnel Folder

Standard Form No. 2810
April 1969
FPM Supplement 890-1

INSTRUCTIONS FOR EMPLOYING OFFICES

PURPOSE OF FORM

This form covers health benefits actions except enrollments, changes of coverage within a plan, and cancellations which are processed on Health Benefits Registration Form (SF 2809). When an action requires a change in health benefits enrollment, prepare SF 2810 as soon as the effective date is known and give the appropriate copies to the enrollee and payroll office immediately. Preparation and distribution of copies should not be delayed pending SF 50 action in the case of transfers to another payroll office.

PROMPT ACTION REQUIRED FOR CONVERSION

To be eligible to convert to a nongroup contract, enrollee must furnish his copy of this notice to his Plan not later than 31 days after the date shown in Part A, item 7, or 15 days after the date shown in Part K, whichever gives him more time. Therefore, make this form available to the enrollee as soon as possible.

COMPLETION OF FORM

PART A--IDENTIFYING DATA

1. For items 1, 2, 3, and 6, transcribe from the last SF 2809 or SF 2810, whichever is the most recent.
2. Item 4, use most recent known address.
3. Item 5, use payroll office number of office authorized to process withholdings.
4. Item 7, date as follows for action reported in:
   - B. TERMINATION--Last day of pay period in which separation (or other action terminating enrollment) occurs except, when coverage terminates because of completion of 365 days in nonpay status, use date of 365th day; and, when coverage terminates because of military duty not limited to 30 days or less, use date employee is separated, furloughed, or placed on leave of absence for military duty.
   - C. CHANGE IN PLAN--Last day of pay period preceding effective date of election to change plans.
   - D. TRANSFER OUT--Actual date.
   - E. TRANSFER IN--Actual date.
   - F. SUSPENSION--Actual date.
   - G. REINSTATEMENT--Actual date.
   - H. CHANGE IN NAME OF ENROLLEE--Actual date.
   - I. CHANGE IN ENROLLMENT--SURVIVOR ANNUITANT--Effective date of sole survivor's annuity.

PART B--TERMINATION

These most frequently occurring actions terminate enrollment with enrollee eligible to convert to individual contract:

- Separated
- Furloughed by reason of reduction in force
- Retired--not eligible to continue enrollment
- Died--no survivor eligible to continue enrollment
- Termination of title to annuity or compensation
- Changed to excluded position or category
- 365 days nonpay status completed
- Entered military duty not limited to 30 days or less
- Employee organization gives notice to terminate employee's enrollment in organization's plan.

PART D--TRANSFER OUT

Losing office use this box to report transfer actions, such as:

- Transferred to another agency or payroll office number (do not use SF 2810 for transfer between employing offices serviced by the same payroll office number)
- Retired--Transfer to a retirement system--employee appears eligible to continue enrollment as an annuitant
- Death--Transfer to retirement system--survivor appears eligible to continue enrollment as a survivor annuitant.
- Transferred to Bureau of Employees' Compensation.

PART E--TRANSFER IN

Gaining office use this box to report transfer actions, such as:

- Acceptance of transfer from another agency or payroll office number
- Retired--Acceptance of transfer by retirement system because employee is eligible to continue enrollment as a survivor annuitant
- Death--Acceptance of transfer by retirement system because survivor is eligible to continue enrollment as a survivor annuitant
- Transfer accepted by Bureau of Employees' Compensation.

NOTE: Retirement systems (including BEC) accepting transfer in, show also in "Remarks" whether enrollment is for an "EMPLOYEE ANNUITANT" or "SURVIVOR ANNUITANT."

PART F--SUSPENSION and PART G--REINSTATEMENT

State in "Remarks" reason for any action not applicable to active military duty such as "Reinstatement of erroneous separation."

PART H--CHANGE IN NAME OF ENROLLEE

Use this box only for reporting changes in name where change of coverage within a plan by SF 2809 is not involved. Show date of birth only where enrollment is changed from employee's or annuitant's name to name of survivor annuitant.

PART I--CHANGE IN ENROLLMENT--SURVIVOR ANNUITANT

Only agencies administering retirement systems will make this determination on the basis of documentary evidence that there is only one survivor annuitant.

PART J--REMARKS

Use this box to bring to the attention of the employee, annuitant, or insurance carrier any pertinent information to clarify or support the action being taken.

PART K--DATE OF NOTICE

Facsimile signature is acceptable. Date as of day of issuance.

DISPOSITION

ORIGINAL--Deliver (or mail) to employee, annuitant, or survivor at earliest possible date. In case a termination SF 2810 must be issued more than 75 days after the effective date of termination, destroy the original copy.

DUPLICATE and TRIPLICATE--Send to appropriate payroll office.

QUADRUPLICATE--File in Official Personnel Folder (or its equivalent) except in cases of death or retirement reported as "Transfer Out" to a retirement system (included Bureau of Employees' Compensation). In latter cases, send the triplicate copy of each Health Benefits Registration Form (SF 2809) accepted from the employee including any Medical Certificates attached thereto and this quadruplicate SF 2810 to appropriate payroll office for transmission to agency or office administering retirement or compensation system.

Standard Form No. 2809
CHAPTER 1-5 F.P.M.
6 GAO 0065

HEALTH BENEFITS REGISTRATION FORM
FEDERAL EMPLOYEES HEALTH BENEFITS ACT OF 1959
(Read instructions on back of last page. Use only typewriter or ballpoint pen.)

CARRIER'S CONTROL NO. 4439942

PART A — ALL WHO REGISTER MUST FILL IN THIS PART.

1. NAME (LAST) (FIRST) (MIDDLE INITIAL): CARANCI John E.

2. DATE OF BIRTH (Use numbers): MONTH 2 | DAY 7 | YEAR 1922

3. Are you now married? YES [4] 1 NO [ ] 2

4. YOUR MAILING ADDRESS (NUMBER AND STREET) (CITY AND ZONE NUMBER) (STATE): 308 ASHTON ST. Alex. 2a.

5. SEX: MALE [4] 1 FEMALE [ ] 2

6. Are you covered by, or is any family member listed below covered by or enrolling in, a plan under the Federal Employees Health Benefits Act of 1959 (through the enrollment of another United States or District of Columbia Government employee or annuitant)? YES [X] NO [ ]

7. Place an "X" in proper box to show your annual basic salary range.
- UNDER $4,000 [ ] 1
- $4,000 TO $5,999 [ ] 2
- $6,000 TO $9,999 [X] 3
- $10,000 OR OVER [ ] 4

PART B — FILL IN THIS PART IF YOU WISH TO ENROLL IN A HEALTH BENEFITS PLAN.

1. I elect to enroll in a health benefits plan as shown below. I authorize deductions to be made from my salary, compensation, or annuity to cover my share of the cost of the enrollment. *(Copy the information requested below from inside cover of brochure of the plan you select.)*

NAME OF PLAN	OPTION (HIGH OR LOW)	ENROLLMENT CODE NUMBER
ASSOCIATION Plan	High	4 2 2

2. In space below list all eligible family members without exception: List your wife or husband first, then your unmarried children under age 19, including legally adopted children, and stepchildren and illegitimate children who live with you in a regular parent-child relationship. Include also any unmarried child over 19 who became disabled before age 19 and who, because of the disability, is incapable of self-support. *(Attach a doctor's certificate for a disabled child age 19 or over.)*

	NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)		NAMES OF FAMILY MEMBERS	DATE OF BIRTH (Month, Day, Year)
Wife or ~~Husband~~			6	not covered as of 1 Mar. 63 (divorced)	
			7		
			8		
			9		
			10		

If enrollment is for self only, answer item 1. If enrollment is for self and family, also answer item 2 and item 3 if it applies.

THIS PART MUST ALSO BE FILLED IN IF YOU CHANGE YOUR ENROLLMENT.

3. If you are a female (employee or annuitant)—does the family listed above include a husband who is incapable of self-support by reason of mental or physical disability which can be expected to continue for more than one year? *(If answer is "Yes," attach a doctor's certificate.)* YES [ ] NO [ ]

PART C — FILL IN THIS PART IF YOU WISH **NOT** TO ENROLL OR IF YOU WISH TO CANCEL YOUR ENROLLMENT.

PLACE AN "X" IN ITEM 1 OR ITEM 2, WHICHEVER APPLIES AND ANSWER ITEM 3.

1. I elect not to enroll in any plan under the Health Benefits Act. [ ]

2. I elect to cancel my present enrollment under the Health Benefits Act. [ ]

3. The reason for my election is *(Place an "X" in proper box)*:
- (a) I am covered by a plan under the Health Benefits Act through the enrollment of my husband, wife, or parent. [ ] 1
- (b) I am covered by a health insurance plan which is not under the Health Benefits Act. [ ] 2
- (c) Any other reason. [ ] 3

PART D — FILL IN THIS PART IF YOU WISH TO CHANGE YOUR ENROLLMENT.

I elect to change my enrollment as shown by the enrollment number and other information in Part 8.

1. Enrollment code number of present plan: 4 | 2 | 5

2. Number of event which permits change. *(See table on back of duplicate for proper number.)*: 7

3. Date of event which permits change: MONTH Aug | DAY 21 | YEAR 61

PART E — ALL WHO REGISTER MUST FILL IN THIS PART.

John E. Caranci 21 Aug 61
(YOUR SIGNATURE—DO NOT PRINT) (DATE)

WARNING.—Any intentional false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

PART F — TO BE COMPLETED BY AGENCY.

1. NAME AND ADDRESS OF EMPLOYING OFFICE

HEALTH BENEFITS OFFICER
(SIGNATURE OF AUTHORIZED AGENCY OFFICIAL)

2. DATE RECEIVED IN EMPLOYING OFFICE: 8/21/61

3. EFFECTIVE DATE OF ELECTION: 9/17/61

4. PAYROLL OFFICE NO.

5. PAYROLL ACTION (INITIALS AND DATE)

REMARKS — FOR USE ONLY BY ANNUITANTS AND AGENCY.

INSTRUCTIONS FOR EMPLOYEES AND ANNUITANTS

(READ CAREFULLY BEFORE COMPLETING FORM)

GENERAL INSTRUCTIONS

COMPLETION OF FORM

1. All employees eligible to enroll must complete and file a Health Benefits Registration Form with their employing office.

2. Use only typewriter or ballpoint pen. Sign Part E and submit all copies to your employing office. Do not detach.

3. If you wish to enroll, fill in Parts A, B, and E.

4. If you do not wish to enroll or if you are enrolled and wish to cancel your enrollment without joining another plan, fill in Parts A, C, and E.

5. If you wish to change your enrollment from self only to self and family (or the reverse) or if you wish to change from your present plan or option to another plan or option, fill in Parts A, B, D, and E.

6. If you need information or help, consult the person or office which usually advises you on personnel matters. You can also obtain information and assistance from any office of the U.S. Civil Service Commission.

ANNUITANTS

1. If you are an annuitant under the Civil Service Retirement System, the Bureau of Retirement and Insurance, U.S. Civil Service Commission, Washington 25, D.C., acts as your "employing office."

2. If your annuity is being paid by a system other than the Civil Service Retirement System, the agency which authorizes payment of your annuity acts as your "employing office."

3. If you are in receipt of monthly compensation under the Federal Employees' Compensation Act and have been found unable to return to duty, the Bureau of Employees' Compensation, Department of Labor, Washington 25, D.C., acts as your "employing office."

4. In filling out the registration form show in the box labeled "Remarks," your annuity (or compensation) claim number, and the name of the agency which acts as your "employing office."

MEDICAL CERTIFICATES

1. If you enroll for self and family and the family includes a husband or a child over age 19 who is incapable of self-support because of mental or physical disability, you must attach a certificate signed by a doctor which gives the following information:

   A. The name of your husband or child.
   B. The nature of your husband's or child's disability.
   C. The period of time the disability has existed.
   D. The probable future course and duration of the disability.
   E. The doctor's name and address.

2. The decision of your employing office concerning the disability is final and unless your husband's or child's disability is considered permanent, the doctor's certificate may have to be renewed from time to time.

3. In the case of a disabled child under age 19 whose disability is expected to continue beyond age 19, a doctor's certificate should be filed with your employing office on or before the child's nineteenth birthday; otherwise, he may no longer be covered as a member of the family.

EFFECTIVE DATE

1. If you register to enroll or change your enrollment, your enrollment or change generally will be effective on the first day of the first pay period which begins not less than 14 days after your registration form is received by your employing office, provided you were in a pay status at any time during the preceding pay period (preceding six pay periods for substitutes in the postal field service).

2. If you register to enroll or to change your enrollment during a REGULAR opportunity (see Parts C and D below), your enrollment or change will be effective on the first day of the first pay period which begins after October 31 of the year in which the REGULAR opportunity occurs, provided you were in a pay status at any time during the preceding pay period (preceding six pay periods for substitutes in the postal field service).

SPECIFIC INSTRUCTIONS

PART A

If your wife or husband works for the Government, you may each enroll for self only or one of you may enroll for self and family. No person may be enrolled both as an employee or annuitant AND as a member of a family. (If you are covered as a member of the family through the enrollment of your spouse or parent, you must register, but you cannot elect to enroll.)

PART B

1. The enrollment code number you fill in shows the plan and option in which you will be enrolled. It also shows whether you are enrolling for self only, self and family, or whether you are enrolling for your family as a female employee with a nondependent husband. *Be sure you copy the name of the plan and the enrollment code number from the brochure correctly.*

2. If you enroll in a comprehensive plan (group-practice or individual-practice), be sure you are in the geographic area served by the plan; otherwise, your enrollment may be void and you may not be entitled to benefits.

3. If you enroll in an employee organization plan, you must be a member of the organization which sponsors the plan. Your membership will be verified. If you are not a member in good standing, your enrollment will be void and you will not be entitled to benefits.

4. After you file the registration form, you do NOT have to report future changes in your family or in your address to your employing office, although the plan in which you enroll may ask you to supply it directly with this information.

PART C

1. If you elect not to enroll, you will have other REGULAR opportunities to join a plan. The first regular opportunity will be between October 1 and 15 of 1961. The Civil Service Commission will prescribe additional regular opportunities to enroll at least once every three years.

2. If you do not enroll in a plan (or cancel your enrollment), you may later have a SPECIAL opportunity to enroll, as explained under Part D.

3. You may register to cancel your enrollment at any time. A cancellation is effective on the last day of your pay period following the one in which the cancellation is received by your employing office.

PART D

1. You will have your first REGULAR opportunity to change your enrollment from self only to family, or the reverse, or to change from one plan or option to another between October 1 and 15 of 1961. The Civil Service Commission will prescribe additional regular opportunities to change your enrollment at least once every three years.

2. You may have one or more SPECIAL opportunities to change your enrollment; or, if you previously elected not to enroll, you may have a SPECIAL opportunity to enroll in a plan. These SPECIAL opportunities are granted for certain specified reasons (for example, a change in your marital or family status), and the change must be made within a specified time limit. A table explaining the various opportunities to change appears on the back of the duplicate of the registration form.

PART E

If you are registering for an employee or annuitant under a written authorization from him to do so, sign your name and attach the written authorization.